**STATE OF MICHIGAN**

**DEPARTMENT OF LABOR & ECONOMIC GROWTH**

**OFFICE OF FINANCIAL AND INSURANCE SERVICES**

**Before the Commissioner of Financial and Insurance Services**

**In the matter of**

**XXXXX** **File No. 87380-001**
**Petitioner**
**v**

**Aetna Life Insurance Company**
**Respondent**
_____/

**Issued and entered**
**This 6th day of March 2008**
**by Ken Ross**
**Commissioner**

**ORDER**

**I**
**PROCEDURAL BACKGROUND**

On January 24, 2008, **XXXXX** (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the information and accepted the request on January 31, 2008.

The Commissioner notified Aetna Life Insurance Company of the external review and requested the information Aetna used in making its adverse determination. Aetna provided information on January 24 and February 1, 2008.

The Petitioner has health care coverage under a group policy. The issue here can be decided by applying the terms of the certificate of coverage (the certificate), the contract that defines her health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review

organization.

## II
## FACTUAL BACKGROUND

The Petitioner's primary care physician (PCP) referred her to Dr. **XXXXX**, a rheumatologist. Dr. **XXXXX** is a non-preferred care provider, i.e., he has not contracted with Aetna to provide services at a negotiated rate. When a claim was submitted for an office visit on October 19, 2007, Aetna paid it at the non-preferred care level of benefit.

The Petitioner appealed. Aetna reviewed her claim but upheld its decision and sent the Petitioner a final adverse determination dated January 4, 2008.

## III
## ISSUE

Was Aetna required to pay more for the Petitioner's office visit on October 19, 2007?

## IV
## ANALYSIS

Petitioner's Argument

The Petitioner needed to see a rheumatologist because of joint problems. When her PCP could not find a preferred care provider in the Petitioner's area, she was referred to Dr. Head and saw him on October 19, 2007.

Although Aetna informed the Petitioner in its final adverse determination that there were two preferred care rheumatologists in her area, the Petitioner says that one (Dr. **XXXXX**) was not a preferred provider until November 3, 2007, and the other (Dr. **XXXXX**) did not open her office until December 26, 2007.

The Petitioner argues that under the circumstances Dr. **XXXXX** should be considered a preferred care provider. She does not believe Aetna should penalize her because there were no preferred care doctors at the time within an acceptable distance.

Aetna Life Insurance Company's Argument

Aetna says that under the Petitioner's plan the level of coverage is based on the network status of a provider. The Petitioner's policy has this definition of preferred care provider:

> **Preferred Care Provider** is a health care provider that has contracted to furnish services or supplies for a Negotiated Charge; but only if the provider is, with Aetna's consent, included in the Directory as a Preferred Care Provider.

The certificate explains that the amount of medical expense paid by Aetna depends on whether or not the provider is a preferred care provider:

> **Comprehensive Medical Coverage**
>
> *** * ***
>
> Benefits may vary depending upon whether a Preferred Care Provider is utilized.
>
> * * *
>
> **Payment Percentage**
>
> The Payment Percentage applies after any deductible amounts.
>
> * * *

| **Preferred Care** | **Non-Preferred Care** |
|---|---|
| Non-surgical Office Visits - 100% after a $20 co-pay | 60% |

Aetna says it does not require that its insureds use any one particular provider -- they are free to choose providers. However, Aetna further says that if providers that are not contracted with Aetna are used, then benefits are limited to a reasonable and customary charge and the member is responsible for any charges in excess of the reasonable and customary charge as well as any deductible and copayment.

Aetna asserts that it has processed the claims correctly.

Commissioner's Review

While the Petitioner's plan covers services from non-preferred providers, those services are subject to a higher coinsurance so the Petitioner has more out-of-pocket expense. Non-preferred providers do not have contracts with Aetna and so the Petitioner does not receive the same discounts as with a network provider. Non-preferred care providers have not agreed to accept Aetna's negotiated rate as payment in full and may bill for the difference between their charge and

Aetna's reasonable and customary fee for a service.

The Petitioner believes her out-of-network doctor should be considered as in-network because there were no network providers in the area where she lives. However, Aetna is correct: its level of coverage is based on the network status of the provider. There is nothing in Aetna's certificate that requires it to cover non-emergency services at the preferred care level even if there are no network providers available.

After reviewing the record, the Commissioner finds that Aetna was correct in processing the claims for Dr. Head's services at the non-preferred level according to the terms and conditions of the certificate.

## V
## ORDER

The Commissioner upholds Aetna's adverse determination of January 4, 2008.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.